Member Designated Release of Information

I designate the person(s) named below to receive information from Coventry Health Care of Nebraska, Inc. about my benefits, on my behalf, in order to assist me in resolving questions about my health care coverage. I understand that this information may include Protected Health Information and other information protected by law. I agree that Coventry Health Care of Nebraska may share this information with the person(s) designated below.

By signing this form, I release Coventry Health Care of Nebraska from any liability of any nature in connection with its release of my Protected Health Information to the person(s) designated below consistent with the terms of this form and any use, misuse or secondary release of such information by the person named below.

I understand that this designation will be effective until I notify Coventry Health Care of Nebraska otherwise. I understand that I may change or cancel this request by sending my change in writing to the address below.

Member Name: _____

Member ID Number: _____

Member Signature: _____ Date: _____

Other Signature: _____

(If someone other than the Member is signing this form; i.e., Health Care Power of Attorney or Legal Guardian, sign your names and your relationship to the member. Attach appropriate documentation to this form if it has not been previously submitted to Coventry Health Care.)

Designated Individual Information:

Designee Name: _____

Relationship to Member: _____

Designee Address: _____

City, State ZIP: _____

Designee Phone Number: _____

Send this form to:
P.O. Box 7705
London, KY 40742